U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 16 February 2005

CASE No.: 2003-BLA-06216

In the Matter of

HAYWARD PAYNE
Claimant

v.

HOBET MINING COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-interest

Appearances:

Hayward Payne
Pro Se

Dorothea J. Clark, Esquire
For Employer

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

[1] The regulations cited are the amended regulations, effective January 19, 2001, found at 20 C.F.R. § 718, et. seq. (2001).

On June 13, 2003, this case was referred to the Office of Administrative Law Judges for a formal hearing. DX 33. Subsequently, the case was assigned to me. A hearing was held on September 2, 2004 in Charleston West Virginia. At the hearing, Director's Exhibits 1 through 35 were admitted to the record, and Employer's evidence was admitted as described herein. The record was kept open pending receipt of the deposition transcript of Employer's medical expert, which was admitted to the record on October 4, 2004. The Claimant was given additional time to submit evidence, but declined to do so. Employer submitted a brief on November 1, 2004. Claimant did not submit a brief. The decision that follows is based upon an analysis of the record, the arguments of the parties and the applicable law.

I. ISSUES

The following issues are presented for adjudication (DX 37):

(1) whether Claimant has pneumoconiosis;

(2) whether Claimant's pneumoconiosis arose out of coal mine employment;

(3) whether Claimant is totally disabled;

(4) whether Claimant's total disability is due to pneumoconiosis;

(5) whether Claimant worked at least 30 years in or around one or more coal mines;

(6) whether Claimant has any dependents for purpose of augmentation and

(7) whether Claimant's most recent period of cumulative employment of not less than one year was with Employer.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Hayward Payne ("Claimant" hereinafter) initially filed a claim for benefits on September 12, 2001. DX 2. Claimant was denied benefits on February 25, 2003 by the District Director. DX 25. Claimant appealed this decision and requested a formal hearing on March 20, 2003. The hearing was scheduled for September 2, 2004 in Charleston, West Virginia. Claimant appeared, pro se, and discussed his difficulty getting counsel. After colloquy with me, he agreed to go forward with the hearing, representing himself.

B. Factual Background

Claimant's first coal mine employment was at Old Boone County Coal Corporation in 1970. Tr. at 18. Old Boone was bought by Employer. Id. Claimant stated that he worked there for 25 years. Id. Claimant worked mainly in the face area of the mines. Id. Claimant last worked in the mines as a scoop operator. Id. at 24-25. Claimant occasionally had to engage in

heavy lifting, usually miner cable. Id. at 25. Claimant last worked in the mines on December 11, 2000, until he was laid off (Tr. at 18), and has not worked since leaving the mines (Id. at 26).

Claimant started to experience breathing problems some years ago, and said that he wheezes and coughs. Id. at 19. He uses inhalers and takes other medication for his breathing problems. Tr. at 19; 21-22. Claimant was treated by Dr. Cook and currently treats with Dr. Chapman. Id. at 20. Claimant's other health problems include knee surgery and arthritis. Id. Claimant is currently on six medications for breathing, arthritis and acid reflux. Id. at 21-22. Claimant would be unable to return to work in the mines because of his breathing, even if he had no other health problems. Id. 23. Claimant has been married to his wife for 36 years, and no other dependents live with him. Id. at 23.

Claimant smoked approximately 2 packs per day for many years, but stopped smoking in 1979. Id. Claimant washes dishes, sweeps the floor and mows his lawn with a rising lawn mower. Id. at 27.

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant must establish that he worked in or around coal mines, and additionally bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. *Director, OWCP v. Greenwich Collieries,* 512 U.S. 267 (1994).

III. ELEMENTS OF ENTITLEMENT

1. Length of Coal Mine Employment

Employer concedes that Claimant worked in the mines for at least three years. Tr. at 17. Claimant credibly testified that he worked in coal mine employment from August 1970 until December, 2000. Tr. at 18-19. The District Director, Office of Workers' Compensation Programs, U.S. Department of Labor ("Director") concluded that Claimant worked for 30 years in the nation's coal mines. DX 25. Claimant's social security account records corroborate Claimant's testimony and support the Director's conclusions that he worked in coal mine employment for thirty years. I find this to be well documented and consistent with the record.

2. Dependents

The record supports the finding that Claimant's wife Shelva Adkins Payne is his dependent for purposes of entitlement under the Act.

3. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4):

(1) X-ray evidence. § 718.202(a)(1).

(2) Biopsy or autopsy evidence. § 718.202(a)(2).

(3) Regulatory presumptions. § 718.202(a)(3).

a) § 718.304 - Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one of more coal mines prior to June 30, 1971.

(4) Physician's opinions based upon objective medical evidence § 718.202(a)(4).

The Fourth Circuit has held that the administrative law judge must weigh all evidence together pursuant to 20 C.F.R. § 718.202(a) to determine whether an individual has coal workers' pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F. 3d 203 (4th Cir. 2000).

X-ray evidence, § 718.202(a)(1)

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102. Pursuant to 20 C.F.R. § 725.414(a)(2)(i) and (3)(1), a party may submit no more than two chest X-ray interpretations in support of its position, and may present a physician's interpretation of each chest X-ray study submitted by an opposing party. In addition, a party may submit an additional statement from the physician who interpreted an X-ray if contrary evidence is presented by an opposing party. At the hearing, I excluded certain X-rays submitted by Employer as being in excess of the number permitted by prevailing regulations.

In assessing the weight to accord to X-ray readings, I may rely on the expertise of the physician interpreting the study. *Aimone v. Morrison Knudson Co.,* 8 B.L.R. 1-32, 34 (1985); *Martin v. Director, OWCP*, 6 B.L.R. 1-535, 537 (1983). A B-reader ("B") is a physician who

has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51 A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. *Scheckler v. Clinchfield Coal Co.* 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984); *Gleza v. Ohio Mining Co.*, 2 B.L.R. 1-436 (1979).

I admitted the following chest X-ray evidence into the record:

DATE OF X-RAY	DATE READ	EX NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	INTERP.
3/18/02	6/1/02	DX 15	Wheeler	BCR, B	Negative
10/22/03	10/27/03	EX 5	Zaldivar	B	Negative
11/6/01	11/6/01	DX 13	Ranavaya	B	Positive
11/6/01	7/3/02	DX 16	Wheeler	BCR, B	Negative

Dr. Ranavaya interpreted the X-ray that he took on November 6, 2001 as being positive for the presence of pneumoconiosis. This X-ray was later interpreted by Dr. Wheeler, who is both a B-reader and a board certified radiologist. He read the X-ray as negative. In consideration of his superior credentials, I accord more weight to Dr. Wheeler's interpretation, and find that the X-ray of November 6, 2001 is negative. DX 10; DX 15. It is significant to note that Dr. Zaldivar, also a B-reader, agreed with Dr. Wheeler's interpretation. EX 2, 9.

Two additional X-rays are of record, both of which were interpreted as negative. The X-ray study of March 18, 2002 was interpreted as negative by a dually qualified radiologist. DX 15. The film taken on October 22, 2003 was interpreted as negative by a physician qualified as a B-reader. EX 5. The record is devoid of contrary opinions regarding these X-ray interpretations. Consequently, I find that both the X-ray of March 18, 2002 and of October 22, 2003 are negative for pneumoconiosis.

Considering all of the X-ray evidence together, I find that the weight of the X-ray evidence does not support a finding of the presence of pneumoconiosis.

Biopsy or autopsy evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

Regulatory presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, § 718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.204(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201 (a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

The record contains the following physician's opinions:

<u>Dr. Mohammed Ranavaya (DX 9)</u>

Dr. Ranavaya examined the Claimant on November 6, 2001. The doctor recorded Claimant's reported coal mine employment of more than 30 years in underground mines. Dr.

Ranavaya also documented Claimant's subjective symptoms of daily wheezing, coughing, sputum, and dyspnea and occasional chest pain. The doctor reported that Claimant "complain[ed] of shortness of breath upon mild to moderate exertion. He becomes short of breath when walking about 100 feet on level ground, about 25-50 feet up a gentle incline or up about 10 steps."

Claimant reported no hospitalizations or surgeries, and no other medical conditions other than arthritis, carpal tunnel syndrome and hearing loss. The Claimant reported a history of smoking a pack of cigarettes a day from 1955 until he stopped in 1979. Claimant's height was recorded at 69". Examination of his throat and lungs showed no abnormalities although "minimally prolonged exp[iratory] phase w[ith] scattered few expiratory wheeze" was observed upon auscultation. Examination of his physical systems was within normal limits or negative. Claimant submitted to a chest X-ray, a pulmonary function study, an arterial blood gas study and an EKG. The doctor found radiological evidence of pneumoconiosis, and considering Claimant's more than 30 years in coal mine employment, diagnosed him with the disease.

Dr. Robert J. Crisalli (DX 15; EX 9)

The doctor examined the Claimant on March 18, 2002, and documented his work as a "continuous miner operator for about twenty five years over the time from 8/25/70 to 12/11/00."[2] The doctor observed Claimant's complaints of ten years of dyspnea and morning cough with sputum. He also noted that Claimant complained of wheezes and snoring, with daytime fatigue. Claimant's medical history was documented and included episodes of bronchitis. The doctor's examination showed no rales or wheezes for prolonged expiration and his cardiovascular system exhibited no significant abnormality other than elevated systolic blood pressure. In a report of April 22, 2002, the physician noted that after his examination of the Claimant, he "arrived at the following diagnoses: simple coal worker's pneumoconiosis, emphysema, asthma, chronic bronchitis, obstructive sleep apnea (based on clinical grounds) and peptic ulcer disease".

The doctor recorded the Claimant's history of smoking one to two packs of cigarettes daily for almost thirty (30) years and reiterated the Claimant's medical and personal history and reported symptoms. The doctor noted that a chest X-ray had been interpreted as positive. Based upon his examination and review of test results, Dr. Crisalli diagnosed Claimant with simple coal workers' pneumoconiosis, with a mild degree of pulmonary function impairment that was consistent with emphysema.

Dr. Crisalli based his diagnosis of emphysema "on the pulmonary function studies which show obstruction to airflow with a severe degree of air trapping. This emphysema and the pulmonary function pattern are characteristic of individuals with heavy smoking histories and not characteristic of individuals with coal worker's pneumoconiosis". The doctor further diagnosed bronchitis based on his history of coughing and sputum, which he concluded could contribute to the obstruction of airflow. Because the pulmonary function studies demonstrated some reversibility, Dr. Crisalli also diagnosed Claimant with asthma. The doctor based his diagnosis

[2] The doctor later clarified his documentation and accepted that Claimant had worked for at least 30 years in the mine, which is indicated by his numerical notations.

of simple coal workers' pneumoconiosis on the basis of his history of coal mine employment and the chest X-ray evidence that he reviewed.

In a letter dated June 24, 2002, Dr. Crisalli addressed his review of additional evidence, including a rereading of the March 18, 2002 X-ray that was performed at the time of his examination of the Claimant. Dr. Crisalli changed his diagnosis about the existence of coal workers' pneumoconiosis because it was based upon objective evidence that he had reason to believe was not reliable. He now agreed that the X-ray was negative for pneumoconiosis, in reliance upon the credentials of the physician who re-read the X-ray, Dr. Wheeler.

Dr. Crisalli testified at a deposition held on September 13, 2004. Dr. Crisalli is board certified in internal medicine and pulmonary diseases. EX 9 at 6. His practice has included the treatment of coal miners, and he is familiar with the manifestations and treatment of pneumoconiosis. EX 9 at 7-8. The doctor clarified that his interpretation of the Claimant's smoking history was thirty-pack years rather than thirty chronological years of smoking. The Claimant smoked for about twenty chronological years. EX 9 at 11-12. The doctor explained that many of Claimant's symptoms were more consistent with asthma, or attributable to his smoking history rather than pneumoconiosis. EX 9 at 15-18. The doctor described the indications for Claimant's prescribed medications and concluded that they would not be effective for treating coal mine dust induced lung disease. EX 9 at 22. The doctor also was of the opinion that the pulmonary function studies, while showing an obstruction, did not produce results consistent with pneumoconiosis. EX 9 at 24-27. Dr. Crisalli reviewed a number of X-rays, and given the interpretations by qualified physicians, concluded that they did not establish the presence of pneumoconiosis. EX 9 at 35-37. He concluded that in consideration of all of the evidence, the Claimant does not have pneumoconiosis. EX 9 at 37-38.

Dr. George L. Zaldivar (EX 2; EX 8)

Dr. Zaldivar examined Claimant on October 22, 2003, and observed that his chief complaint was shortness of breath, which he has experienced for 10 to 12 years. Claimant also reported wheezing and having a daily productive cough. The doctor documented Claimant's smoking history as one to two packs a day until 1979. His coal mine employment of more than 30 years was also documented. The doctor recorded Claimant's blood pressure as 150/80, and noted no murmurs or gallops. His lungs showed few expiratory rhonchi after the breathing test. The doctor recorded his impression of asthma and emphysema.

In his report of November 20, 2003, Dr. Zaldivar summarized his observations and findings from his examination of the Claimant on October 22, 2003. Dr. Zaldivar's report also includes his review of reports and tests completed by other medical experts, including Drs. Ranavaya and Crisalli. Dr. Zaldivar found "no radiographic evidence of pneumoconiosis" and "normal cardiopulmonary response to exercise, which was stopped due to left knee pain and shortness of breath." The doctor observed that "[t]he shortness of breath was not justified by the data obtained." The doctor further found that Claimant has moderate reversible airway obstruction, and normal diffusion capacity. He concluded that Claimant has asthma, which is being treated. He found no evidence of pneumoconiosis.

Discussion

Dr. Zaldivar testified by deposition on December 30, 2003. The doctor is board certified in internal medicine and pulmonary medicine and is a B-reader. EX 8 at 3. He reported that Claimant had advised him that he experiences wheezing and shortness of breath, as well as daily coughing. The doctor observed that Claimant's physician treated him with medications that are used to treat asthma. EX 8 at 8. His examination of Claimant revealed the presence of rhonchi, which indicates partial obstruction or secretions in the airways. EX 8 at 10. The doctor concluded that Claimant had a moderate airway obstruction that was not attributable to pneumoconiosis because there was no abnormality in diffusion capacity. He found that Claimant's arterial blood gas studies were normal. EX 8 at 14-22. The X-ray that Dr. Zaldivar took showed no abnormalities. EX 8 at 24. The doctor also was influenced by Dr. Wheeler's negative reading of X-rays in his conclusion that Claimant does not have pneumoconiosis. EX 8 at 25-28. Dr. Zaldivar also disagreed with Dr. Crisalli's opinion that Claimant has emphysema, because he did not find an abnormality of diffusion capacity. EX 8 at 30.

I find that the opinions of Dr. Zaldivar and Dr. Crisalli are both reasoned and well-documented. A documented opinion is one that sets forth the clinical findings, observations, facts and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295 (1984). An opinion is reasoned when the underlying data and documentation are adequate to support the physician's conclusions. *Fields,* supra. Both physicians examined the Claimant, conducted objective medical tests and considered their results, along with the other medical evidence of record in reaching their conclusion that Claimant does not have pneumoconiosis. Both doctors gave well reasoned explanations for their determination that the test results showed some pulmonary impairment that did not manifest itself as they would expect if pneumoconiosis was responsible for the condition. The doctors placed significant weight upon the medical X-ray interpretations of Dr. Wheeler who is dually qualified as a board certified radiologist and B-reader. In addition, Dr. Zaldivar is a B-reader, and his opinion regarding whether the X-ray evidence shows the presence of pneumoconiosis is entitled to additional weight. Although Dr. Crisalli initially found that X-ray evidence was consistent with the presence of simple pneumoconiosis, he concluded upon consideration of Dr. Wheeler's interpretation that the X-ray was negative (EX 9 at 34-38), which is consistent with my findings. At deposition, Dr. Crisalli testified that based upon his review of the X-ray evidence, he did not conclude that Claimant has coal workers' pneumoconiosis. EX 9 at 36-37.

I find that although Dr. Ranavaya's opinion regarding the presence of pneumoconiosis is supported by his own interpretation, that finding is outweighed by the opinions of better qualified medical experts. I therefore accord Dr. Ranavaya's opinion less weight. Moreover, Dr. Ranavaya's opinion is not as well documented, as he did not review all of the medical evidence, including two other X-rays that were taken after his and did not show the presence of pneumoconiosis.

In sum, I find that the chest X-ray evidence is negative for the presence of pneumoconiosis. I also find that the medical opinion evidence does not support a finding that

Claimant has pneumoconiosis. Considering all of the evidence together, I find that it does not establish that the Claimant has pneumoconiosis.

Based on the forgoing, Claimant has failed to establish this element of entitlement.

4. Pneumoconiosis Due to Coal Mine Employment

As Claimant has failed to establish the presence of pneumoconiosis, there is no need to consider this causation element. However, assuming that Claimant had established this element of entitlement, he would be entitled to a presumption that pneumoconiosis arose out of his coal mine employment. See, 20 C.F.R. § 718.203(b). In this event, I would find that the evidence of record rebuts this presumption because well-reasoned and documented opinions attribute his pulmonary impairment to conditions other than pneumoconiosis.

5. Total Disability

Claimant must establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) provides as follows:

> [A] miner shall be considered totally disabled . . . if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner
>
> (i) From performing his or her usual coal mine work; and (ii) From engaging in gainful employment... in a mine or mines...

§ 718.204(b)(1).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right-sided congestive heart failure; or reasoned medical opinion. § 718.204(b)(2)(i-iv). Producing evidence under one of these four ways will create a presumption of total disability only in the absence of contrary evidence of greater weight. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. *Rafferty v. Jones & Laughlin Steel Corp.,* 9 B.L.R. 1-231 (1987). If, however, a nonpulmonary or nonrespiratory condition or disease caused a chronic respiratory or pulmonary impairment, that condition shall be considered and assigned appropriate weight in determining whether the miner was totally disabled [under the Act]. § 718.204(a). See, *Shedlock v. Bethlehem Mines Corp*., 9 B.L.R. 1-195, 1-198 (1986) aff'd on reconsideration en banc, 9 B.L.R. 1-236 (1987).

Pulmonary function study evidence

In order to establish total disability through pulmonary function tests, the FEV_1 must be equal to or less than the values listed in Table B1 of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 for the FVC

test, or (2) values equal to or less than those listed in Table B5 for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. § 718.204(b)(2)(i)(A-C). Such studies are designated as "qualifying" under the regulations. Assessment of pulmonary function study results are dependent on Claimant's height, which was noted most frequently as 70 inches. I used that height in evaluating the studies. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983).

The record contains the pulmonary function studies summarized below.

DATE	EX. NO.	PHYSICIAN	AGE/HT	FEV_1	FVC	EFFORT	QUALIFY
11/6/01	DX 12	Ranavaya	56/ 69"	1.72 1.58*	3.04 2.83*	Maximal	Yes Yes
3/18/02	DX 15	Crisalli	56/70"	1.69 2.19*	3.22 4.00*	Good Co-Operation	Yes No
10/22/03	EX 2	Zaldivar	58/70"	1.76 2.29*	3.70 4.29*	*	Yes No

*post-bronchodilator

November 6, 2001 Pulmonary Function Study

Dr. Ranavaya interpreted the test to show a mixed obstructive/restrictive pattern indicated by the reduction in FEV_1/FVC % and FVC. He characterized the reduction in FVC as mild, and hypothesized that it was due to air trapping associated with airways obstruction. On behalf of the Director, on February 15, 2001, Dr. Gaziano reviewed the test of November 16, 2001 and found the vents acceptable. DX 12. The doctor is board certified in internal medicine and pulmonary disease. Id.

March 18, 2002 Pulmonary Function Study

In his report of April 22, 2002, Dr. Crisalli wrote that the test he administered produced an invalid diffusion study "because the patient was unable to perform this study and meet validity criteria". DX 15. Otherwise, the test results were valid, and the doctor found that the test showed "a moderate expiratory airflow obstruction although there was no plateau on the volume time curve. There was no restrictive defect. There is a severe degree of air trapping based on the lung volume studies. There was a significant improvement after bronchodilators with improvement up to a mild obstructive level." Id. The doctor testified that "[t]he spirometry examination showed a moderate expiratory airflow obstruction although there was no plateau on the volume time curve. There was no restrictive defect. There is a severe degree of air trapping based on the lung volume studies. There was a significant improvement after bronchodilators with improvement up to a mild obstructive level." EX 9 at 24. Dr. Zaldivar testified that Dr. Crisalli's test results were similar to those of the test he administered. EX 8 at 13.

October 22, 2003 Pulmonary Function Study

Dr. Zaldivar conducted this study, and concluded that it showed that the Claimant has moderate reversible airway obstruction. EX 2. The doctor concluded that Claimant's

breathing improved by 15% after application of bronchodilators during the test. EX 8 at 12. The doctor found this a significant improvement. Id.

In view of the test results that demonstrate qualifying results, I find that the pulmonary function study evidence supports a finding of total disability. Although the tests of Drs. Crisalli and Zaldivar demonstrate reversibility after administration of bronchodilators, Dr. Ranavaya's results did not show the same level of reversibility. As all of the tests are valid, I find that they substantially demonstrate qualifying levels.

Arterial Blood Gas Study Evidence

The record contains the arterial blood gas study summarized below.

DATE	EX. NO.	PHYSICIAN	pCO2	pO2	QUALIFIES
3/18/02	DX 15	Crisalli	39	84	No
10/22/03	EX 2	Zaldivar	34 36	100 94	No
11/6/01	DX 11	Ranavaya	35 37	81 100.9	No No

*post exercise

The blood gas studies did not yield qualifying results. Based on the foregoing, the arterial blood gas evidence does not support a finding that Claimant is totally disabled under the provisions of § 718.204(b)(2)(ii).

Evidence of Cor Pulmonale

Under § 718.204(b)(2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure.

Medical Opinion Evidence

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv).

<u>Dr. Ranavaya</u>

Upon his examination of the Claimant on November 6, 2001, the doctor concluded that Claimant had moderate pulmonary impairment that had its etiology in "occupational exposure to

coal mining for 30 ½ years". DX 10. The doctor based this conclusion in part upon his finding radiological evidence of pneumoconiosis as well. Id. Dr. Ranavaya found that Claimant's pulmonary condition would preclude him from working in the mines. Id.

Dr. Crisalli

Dr. Crisalli concluded that the Claimant has a pulmonary impairment that he characterized as emphysema. In his report of April 22, 2002, the doctor wrote "[t]his emphysema and the pulmonary function pattern are characteristic of individuals with heavy smoking and is not characteristic of individuals with coal worker's pneumoconiosis". DX 15. The doctor also observed that Claimant's chronic bronchitis contributed to the obstruction of airflow, and that Claimant "has asthma based on the reversibility demonstrated in the pulmonary function studies". Id. Although the doctor initially found that X-ray evidence showed pneumoconiosis, he reversed his opinion upon other readings of the X-ray evidence. DX 15, EX 9.

Dr. Crisalli characterized the degree of Claimant's pulmonary impairment as "mild" after the use of bronchodilators, and wrote, "{h}is exertional tolerance is not limited by respiratory factors, considering the stress test results." The doctor observed that the stress test "did not represent a maximal effort", and in consideration of the level of Claimant's oxygen consumption at the time the stress test was discontinued, he "retains the capacity to perform heavy work". DX 15. Dr. Crisalli found that Claimant retained the capacity "to perform his previous work in the coal mines or jobs requiring similar effort outside of the mines providing he has had adequate bronchodilator therapy for his asthma. From the pulmonary standpoint, Mr. Payne is not disabled to the extent that he would be unable to perform his regular coal mine job." DX 15. The doctor relied upon the "Guides to the Evaluation of Permanent Impairment, American Medical Association", 5th edition, page 101 in reaching his opinion. Id.

Dr. Crisalli testified that he has significant experience treating coal miners in his pulmonary specialty practice. EX 9 at 6. The doctor acknowledged that is possible for even simple coal workers' pneumoconiosis to cause a totally disabling impairment. Id. at 8. The doctor described interviewing Claimant when he examined him, and reported that Claimant's work involved standing for eight hours, and lifting material weighing eighty to ninety pounds ten time a day, and carrying the material from fifty to two hundred feet. Id. at 10. Dr. Crisalli classified Claimant's work as "heavy manual labor". Id. The doctor also noted Claimant's history of smoking one to two packs of cigarettes daily for thirty years, which he said is inconsistent with other accounts of his smoking history, which in reality translates into a thirty-pack-year history of smoking. Id. at 10-12.

Dr. Crisalli attributed Claimant's reported symptom of wheezing to asthma. Id. at 13-14. He thought that Claimant's hay fever symptoms would cause respiratory symptoms. Id. at 14. The doctor concluded that Claimant has asthma, and noted that he took asthma medication. Id. at 20-22. Dr. Crisalli explained that Claimant's reported dyspnea is a nonspecific symptom that could be related to lung disease, but could occur as the result of other factors, including obesity or other diseases. Id. at 13. The doctor explained his observation of Claimant's breathing pattern and fatigue that was consistent with sleep apnea. Id. at 15-16. In Dr. Crisalli's opinion,

the Claimant's productive cough "is enough or sufficient…to justify a diagnosis of chronic bronchitis.". Id. at 16. The doctor concluded that both Claimant's coal dust exposure and smoking history could cause bronchitis, but held that "cigarette smoking is the strongest potentiator of chronic bronchitis, far stronger than coal dust exposure." Id. Dr. Crisalli believed that bronchitis could continue even after exposure to coal dust or smoking was terminated. Id. at 17. Dr. Crisalli concluded that in Claimant's case, his smoking history was responsible for bronchitis because the pulmonary function test demonstrated "a significant component of emphysema" as well as asthma. Id. at 17-18. Dr. Crisalli opined that there is no link between asthma and coal dust exposure.

Dr. Crisalli explained that Claimant's "baseline spirometry studies revealed a moderate expiratory air flow obstruction" and "ruled out the presence of a restrictive disease, but they showed a significant degree of air trapping". Id. at 23-24. The doctor attributed the air trapping to Claimant's emphysema and asthma. Id. at 25. He distinguished Claimant's emphysema, which he said was due to smoking, from the kind caused by coal dust exposure because of the pattern of severe lung trapping, which is not seen in individuals with pneumoconiosis, but is common to individuals with emphysema from smoking. Id. at 26-27. Dr. Crisalli found no evidence of gas exchange impairment on the arterial blood gas study, and saw no appreciable defect in oxygenation with exercise. Id. at 28-31. The doctor concluded that the objective tests do not demonstrate that Claimant's pulmonary impairment is due to pneumoconiosis. Id. at 38. Furthermore, the doctor found that Claimant retains the pulmonary functional capacity to perform his previous job in coal mining, or to perform very heavy manual labor. Id. According to Dr. Crisalli, the Claimant's airway disease is reversible, and he is not totally disabled by a respiratory impairment. Id. at 40.

Dr. Zaldivar

The doctor reviewed the medical evidence, including the tests administered by Drs. Ranavaya and Crisalli, and administered his own tests as well. Based upon all of the information he reviewed, Dr. Zaldivar concluded that Claimant has asthma that is treated with medication. EX 2. The doctor concluded that Claimant's asthma imposes a pulmonary impairment that is unrelated to his history of coal mining and that is treatable, but that is not being optimally treated. Id. Dr. Zaldivar concluded that despite evidence of moderate airway obstruction, Claimant was able to exercise, and is not disabled from performing his coal mining work or work requiring comparable exertion. Id. In Dr. Zaldivar's opinion, Claimant would have better pulmonary and exercise capacity if his asthma medication was better. Id.

Dr. Zaldivar testified that Claimant's reported symptom of wheezing is not consistent with a diagnosis of coal workers' pneumoconiosis, but is typical for individuals with asthma. EX 8 at 8. Dr. Zaldivar observed that Claimant is being treated with bronchodilator medications that are usually prescribed for asthma. Id. His examination did not reveal wheezing, but rather a few rhonchi that indicate some sort of partial obstruction or secretions in the airways. Id. at 9. The doctor acknowledged that Claimant's coal mine work history put him at risk for lung disease, as well as does his smoking history. Id. at 10. According to Dr. Zaldivar, even though Claimant stopped smoking in 1979, the lungs may not have healed. Id. The doctor stated: "[i]ndividuals who do have an effect of smoking in their lungs by way of airway obstruction, the

airway obstruction magnifies with age, so it may be present to a lesser extent years before and then, as the lung ages, it appears to have more and more obstruction." Id. at 11. In the doctor's opinion, symptoms of bronchitis may improve after quitting smoking unless actual damage was done to the lungs, as may occur by smoking two packs of cigarettes a day for ten or more years. Id.

Dr. Zaldivar conducted a test of Claimant's breathing that produced values less than normal, but that improved by fifteen percent after the administration of bronchodilators. EX 8 at 12. The test results were consistent with an individual who has asthma, and the doctor noted that his results were similar to those in the test that Dr. Crisalli conducted. Id. at 12-13. Dr. Zaldivar explained that although the test administered by Dr. Ranavaya did not reveal reversibility, some individuals with asthma do not consistently respond to bronchodilators, particularly when they have obstruction in both airways, as does Claimant. Id. at 13-14. The doctor further explained that individuals with pneumoconiosis cannot improve their breathing with bronchodilators because their airways obstruction is caused by destruction of lung tissue, and in such cases, he would not expect to see reversibility of obstruction. Id. at 14.

Dr. Zaldivar also tested Claimant's diffusion capacity with results of eighty-seven percent of what was predicted. Id. at 15. The doctor found these results consistent with asthma, but not with emphysema or coal workers' pneumoconiosis. Id. If pneumoconiosis were present, the doctor would "expect to see some mild impairment of diffusion because the moderate obstruction meant there was a lot of lung tissue destruction." EX 8 at 15. Dr. Crisalli's diffusion test showed a lesser percent of capacity, but Dr. Zaldivar observed that Dr. Crisalli did not think the test was valid. EX 8 at 16. Dr. Zaldivar noted that on that test, Claimant's inspire volume was eighty percent of his forced vital capacity, whereas the optimum inspire volume is ninety percent. Id. at 17. Dr. Zaldivar believed his test was more reliable because the other results underestimate the true diffusion. Id. at 17-18.

Dr. Zaldivar also performed an arterial blood gas test that required Claimant to exercise. EX 8 at 18. Claimant performed well on the test, with low oxygen consumption and ventilatory reserve at the cessation of exercise. Id. at 18-19. The doctor recalled that Claimant stopped exercising due to knee pain. Id. The other arterial blood gas tests of record also produced normal results. Id. at 19.

In consideration of all of the tests, and the medical evidence, Dr. Zaldivar concluded that Claimant has asthma that is treatable, and is unrelated to pneumoconiosis. EX 8 at 20. In the doctor's opinion, coal dust exposure does not cause or contribute to asthma. Id. at 21. The doctor's review of the evidence led him to conclude that Claimant has a reversible obstruction that is not a totally disabling impairment, and that would present little impairment "with maximum treatment". Id. at 21. The doctor concluded that Claimant would be able to perform his work as a miner, but acknowledged that he might experience discomfort from his asthma when pulling cables or performing other heavy labor. Id. at 24. Dr. Zaldivar observed that asthma would not produce abnormalities on a chest X-ray other than "some overinflation if the individual has an acute asthma attack which is quite significant because they will be trapping a lot of air". Id. at 24-25. Dr. Zaldivar discounted Dr. Crisalli's conclusion that Claimant has emphysema, because it appeared to be based upon a diffusion abnormality that was not

demonstrated on the test that Dr. Zaldivar administered. Id. at 30. The doctor did agree with Dr. Crisalli's diagnosis of chronic bronchitis, and stated that bronchitis is associated with asthma. Id.

Discussion

I find that Dr. Crisalli's and Dr. Zaldivar's medical opinions that Claimant is not totally disabled are both reasoned and well-documented. As previously stated, both physicians based their conclusions upon the pulmonary function studies and arterial blood gas studies of record, as well as physical examinations of Claimant. Both doctors, who are board certified pulmonary experts, found that Claimant's test results, as well as his symptoms, correlated with a diagnosis for asthma, and not pneumoconiosis. Dr. Crisalli also found evidence of emphysema, and he discussed Claimant's smoking history as a significant factor in his diagnosis of that disorder. Although Dr. Zaldivar discounted that opinion, Dr. Zaldivar did not provide an analysis of the effect of Claimant's smoking as extensive as Dr. Crisalli's. I do not find this difference of opinion between these two experts sufficient to compromise their ultimate shared conclusion that Claimant does not have a disabling pulmonary impairment. I find that that objective medical evidence supports their opinion.

I place less weight upon Dr. Ranavaya's opinion that Claimant is totally disabled because it is not as well documented as the opinions of the other two physicians of record. Dr. Ranavaya did not have the benefit of reviewing all of the evidence of record. Although his pulmonary function study did not reveal the degree of reversibility that was demonstrated on the other tests of record, I am persuaded by Dr. Zaldivar's explanation that the test was not entirely inconsistent with results produced by an individual with asthma. I also accord additional weight to the opinions of Drs. Zaldivar and Crisalli because of their credentials.

In consideration of the above, I find that the physicians' opinion evidence does not support a finding that Claimant is totally disabled, pursuant to § 718.204(b)(2)(iv).

Additionally, in considering all of the medical evidence together, I find that it fails to support a finding that Claimant is totally disabled. *Rafferty v. Jones & Laughlin Steel Corp*., 9 B.L.R. 1-231 (1987). Based on the foregoing, I find that Claimant has failed to establish total disability under the provisions of § 718.204(b)(2)(i-iv).

6. Total Disability Due to Pneumoconiosis

Since Claimant has not proven total disability, there is no need to resolve the causation issue. Nevertheless, as I have found that Claimant has not established the presence of pneumoconiosis, I find that he is unable to establish this last element of entitlement.

IV. CONCLUSION

As Claimant has failed to establish that he is totally disabled as the result of pneumoconiosis, his claim for benefits under the Act must be denied.

ORDER

The claim of HAYWARD PAYNE for benefits under the Act is DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.